STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Post-Survey Revisit (PSR) to the Investigation of Complaint IN00088724 completed on April 14, 2011. This visit included the Investigation of Complaint IN00090882. This visit included the PSR to the Investigation of Complaints IN00089836, IN00089626, and IN00089748 completed on May 5, 2011. Complaint IN00088724- Not Corrected Survey dates: June 13, 14, 15, and 16, 2011 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Survey team: Anne Marie Crays, RN Census bed type: SNF: 38 SNF/NF: 61 Total: 99 Census payor type: Medicare: 20 Medicaid: 45	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 29, 2011 to the post-survey revisit conducted on June 16, 2011. We respectfully request that you review this information, request any further information you may require, and then consider a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 34 Total: 99 Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 20, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure a staff member [RN # 1] accused of abuse by Resident I was immediately sent home, and was instead allowed to continue her shift for 5	F0225	**F225 It is the practice of this facility to assure that any form of abuse is reported to the Administrator immediately and that any personnel involved are removed from the schedule**	06/29/2011

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	hours, potentially affecting 39 residents residing on the North and South units on which the staff member worked, in a sample of 5 Units, and 1 of 3 residents reviewed for abuse in a sample of 8. Findings include: On 6/13/11 at 10:30 A.M., the Administrator provided a "Facility Incident Reporting Form," sent to the Indiana State Department of Health on 6/10/11. The form included: "...Brief Description of Incident:...At 2:50 am [sic] another aide responded to resident's call light and resident stated that nurse had hit her. Night supervisor notified of allegations...." An accompanying statement, dated 6/10/11, indicated, "...At 2:50am [sic] [CNA # 2] responded to resident's call light and states that resident told her 'that lady hit me again' and that a tall guy was with her. [LPN # 2], night supervisor was notified and spoke with nurse involved as well as resident. [LPN # 2] reports resident was 'pleasant and smiling' at this time...At approx 9:00 a.m., this administrator, the ADON, and the social worker met regarding the incident...No other alert/oriented residents had complaints of mistreatment...SW [social worker] also spoke with resident today and resident did not appear to have memory of any incident last night...[RN #		**pending investigation.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** There have been no further abusive incidents reported since the surveyor exited. Resident I has shown no negative impact related to the documented incident. LPN #2 has been individually educated related to the following of facility policy. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. However, there have been no allegations or observations of incidents of abuse with any other residents since the surveyor exited. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to how to appropriately intervene related to any allegation of abuse has been reiterated with all nursing staff members. The in-service was designed to assure a thorough understanding of the policy including the reporting of abuse to the facility Administrator and assuring that any personnel against which the allegation was made are removed from duty pending the investigation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An updated Performance	

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	1] will be notified that she may return to work as scheduled." A facility "Employee Counselling [sic] Form," dated 6/11/11 and given to LPN # 2, indicated, "...Type of Occurrence: Failure to immediately initiate suspension of staff member when knowledge was received of physical abuse allegation...Solution Discussed: Abuse policy review - with special focus on Reporting Procedures "Any staff member alleged to have abused a resident will immediately be suspended from further time worked. The individual in charge of the staff member will initiate the suspension...." On 6/14/11 at 12:05 P.M., the Administrator provided documentation that RN # 1 worked from 6/9/11 at 11:01 P.M. until 6/10/11 at 8:03 A.M. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she notified her night supervisor at approximately 3:00 A.M., on 6/10/11 that Resident I had complained of RN # 1 hitting her. RN # 1 indicated she did not go into that resident's room for the remainder of her shift, but did work the remainder of her shift. 1. On 6/15/11 at 8:45 A.M., the Assistant		Improvement Tool will be utilized to review the proper following of the abuse policy, including removing any employees from the schedule pending investigation based on the allegation that has been made. The tool will be utilized to review any allegation of abuse. The Administrator, or designee, will complete this audit as any allegations occur for the next 6 months. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** June 29, 2011	

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	Director of Nursing provided the revised facility policy on "Abuse Prohibition," revised 2/11. The policy included: "...Purpose, To ensure that all allegations of abuse are investigated fully for possible substantiation...The alleged staff member will be relieved from his/her duties pending investigation...." This deficiency was cited on 4/14/11 and 5/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policies on abuse prohibition, in that,a staff member [RN # 1] accused of abuse by Resident I was not immediately sent home, and was instead allowed to continue her shift for 5 hours, potentially affecting 39 residents residing on the North and South units on which the staff member worked, in a sample of 5 Units, and 1 of 3 residents reviewed for abuse in a sample of 8. Findings include: 1. On 6/15/11 at 8:45 A.M., the Assistant Director of Nursing provided the revised facility policy on "Abuse Prohibition," revised 2/11. The policy included: "...Purpose, To ensure that all allegations of abuse are investigated fully for possible substantiation...The alleged staff member will be relieved from his/her duties pending investigation...Screening...Each prospective team member will be subject to a criminal history check...."	F0226	**F226 It is the practice of this facility to assure that any form of abuse is reported to the administrator immediately and that any personnel involved are removed from the schedule pending investigation in accordance with facility policy.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** There have been no further abusive incidents reported since the surveyor exited. Resident I has shown no negative impact related to the documented incident. LPN #2 has been individually education related to the following of facility policy. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. However, there have been no allegations or observations of incidents of abuse with any other residents since the surveyor exited. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to	06/29/2011

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	2. On 6/13/11 at 10:30 A.M., the Administrator provided a "Facility Incident Reporting Form," sent to the Indiana State Department of Health on 6/10/11. The form included: "...Brief Description of Incident:...At 2:50 am [sic] another aide responded to resident's call light and resident stated that nurse had hit her. Night supervisor notified of allegations...." An accompanying statement, dated 6/10/11, indicated, "...At 2:50am [sic] [CNA # 2] responded to resident's call light and states that resident told her 'that lady hit me again' and that a tall guy was with her. [LPN # 2], night supervisor was notified and spoke with nurse involved as well as resident. [LPN # 2] reports resident was 'pleasant and smiling' at this time...At approx 9:00 a.m., this administrator, the ADON, and the social worker met regarding the incident...No other alert/oriented residents had complaints of mistreatment...SW [social worker] also spoke with resident today and resident did not appear to have memory of any incident last night...[RN # 1] will be notified that she may return to work as scheduled." A facility "Employee Counselling [sic] Form," dated 6/11/11 and given to LPN # 2, indicated, "...Type of Occurrence: Failure to immediately initiate suspension of staff member when knowledge was		how to appropriately intervene related to any allegation of abuse has been reiterated with all nursing staff members. The in-service was designed to assure a thorough understanding of the regulation including the reporting of abuse to the facility Administrator and assuring that any personnel against which the allegation was made are removed from duty pending the investigation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An updated Performance Improvement Tool will be utilized to review the proper following of the abuse policy, including removing any employees from the schedule pending investigation based on the allegation that has been made. The tool will be utilized to review any allegation of abuse. The Administrator, or designee, will complete this audit as any allegations occur for the next 6 months. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** June 29, 2011	

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	received of physical abuse allegation...Solution Discussed: Abuse policy review - with special focus on Reporting Procedures "Any staff member alleged to have abused a resident will immediately be suspended from further time worked. The individual in charge of the staff member will initiate the suspension...." On 6/14/11 at 12:05 P.M., the Administrator provided documentation that RN # 1 worked from 6/9/11 at 11:01 P.M. until 6/10/11 at 8:03 A.M. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she notified her night supervisor at approximately 3:00 A.M. on 6/10/11 that Resident I had complained of RN # 1 hitting her. RN # 1 indicated she did not go into that resident's room for the remainder of her shift, but did work the remainder of her shift. This deficiency was cited on 4/14/11 and 5/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a lap tray utilized for positioning was placed on a wheelchair as ordered by the physician, for 1 of 4 residents reviewed for falls, in a sample of 8. Resident A Findings include: The clinical record of Resident A was	F0282	**F282 It is the practice of Pine Haven Health and Rehabilitation Center to assure that the residents' care plans are followed appropriately in accordance with the assessed needs. *The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident #A is no longer a resident of the facility. ***Other residents that have the***	06/29/2011

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	reviewed on 6/13/11 at 11:20 A.M. Diagnoses included, but were not limited to, Dementia, Parkinson's disease, and Epilepsy. A Physician's order, dated 4/15/11, indicated, "...May use deluxe tray [with] quick release clamps to w/c to aide [sic] in positioning due to poor posture." A Care Plan, initially dated 5/23/09 and updated 4/15/11, indicated a problem of "Potential for falls R/T [related to]: Attempts to stand unassisted. History of previous falls. Loses balance easily. Unsteady gait...." The Interventions included: "4/15/11 Deluxe tray [with] Quick release clamps to w/c to aide [sic] in positioning d/t [due to] poor posture." Nurse's Notes, dated 4/25/11 at 2:35 A.M., indicated, "Gotten up in w/c in TV lounge. Heard noise resident had fallen out of w/c. Has laceration to forehead [approximately] 3 cm [centimeters] length, width linear 0.1 cm edges approximated [and] steri striped [sic] [after] cleansing...Small am't [amount] bleeding from nose...Has red bruise area [approximately] 2 cm diameter on [right] knee...." On 6/13/11 at 12:15 P.M., the ADON (Assistant Director of Nursing) provided		***potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care. The CNA assignment sheets appropriately address residents' needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has again been in-serviced related to providing services to our residents in correlation with the written plan of care. In addition, there will be additional emphasis for new CNA's related to reviewing their assignment sheets so that they are aware of the plan of care established for the resident. There will be routine monitoring via rounds by nurses and nursing administration to assure that safety devices are in place and functional in accordance with the residents' plans of care. ***The corrective action taken to monitor performance to assure***	

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	an "Incident/Accident Report," dated 4/25/11. The report included: "...Resident attempting to get up unassisted several times wanting to get up...resident gotten up per CNA in w/c, placed in TV lounge...Heard noise, resident on floor, w/c in normal position...Additional comments and/or steps taken to prevent recurrence: Education to new staff importance of CNA assignment sheet to keep on @ all times...." During interview at that time, the ADON indicated he was not employed by the facility on 4/25/11, and did not have additional information. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she was the nurse working when Resident A fell on 4/25/11. RN # 1 indicated a "new CNA" transferred the resident to a wheelchair, and did not place the lap tray on the wheelchair as ordered. This Federal tag relates to Complaint IN00088724. This deficiency was cited on 4/14/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)		***compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents' comprehensive assessment in correlation with the plan of care to assure that the pertinent information based on the assessment is accurately communicated and being followed in accordance with the residents' identified needs. Safety device placement and function will be specifically identified on the monitoring form. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** 6-29-11	

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a lap tray utilized for positioning was placed on a wheelchair, causing the resident to fall and obtain a laceration on her forehead, for 1 of 4 residents reviewed for falls, in a sample of 8. Resident A	F0323	**F323 It is the practice of Pine Haven Health and Rehabilitation Center to assure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent accidents.** ***The corrective action taken for***	06/29/2011

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	Findings include: The clinical record of Resident A was reviewed on 6/13/11 at 11:20 A.M. Diagnoses included, but were not limited to, Dementia, Parkinson's disease, and Epilepsy. An annual Minimum Data Set [MDS] assessment, dated 3/19/11, indicated Resident A had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, was non-ambulatory, and required extensive assistance of one staff for transfer. A Physician's order, dated 3/31/11, indicated, "OT [occupational therapy] eval [evaluation] only for evaluation of improvent [sic] of positioning in w/c [wheelchair] (extreme leaning forward)." An OT note, dated 4/1/11, indicated, "...Reason for Referral:...multiple medical complexities affecting positioning in wheelchair, general weakness and postural fatigue requiring OT intervention due to severe leaning and decreased safety in wheelchair...." A Physician's order, dated 4/15/11, indicated, "...May use deluxe tray [with] quick release clamps to w/c to aide [sic]		***those residents found to be affected by the deficient practice include:*** Resident #A no longer resides at the facility. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care and assessed safety devices. The CNA assignment sheets appropriately address residents needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has again been in-serviced related to providing services to our residents in correlation with the written plan of care. In addition, there will be additional emphasis for new CNA's related to reviewing their assignment sheets so that they are aware of the plan of care established for the resident. There will be routine monitoring via rounds by nurses and nursing administration to	

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	155621	A. BUILDING 00 B. WING	06/16/2011

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	in positioning due to poor posture." A Care Plan, initially dated 5/23/09 and updated 4/15/11, indicated a problem of "Potential for falls R/T [related to]: Attempts to stand unassisted. History of previous falls. Loses balance easily. Unsteady gait...." The Interventions included: "4/15/11 Deluxe tray [with] Quick release clamps to w/c to aide [sic] in positioning d/t [due to] poor posture." Nurse's Notes, dated 4/25/11 at 2:35 A.M., indicated, "Gotten up in w/c in TV lounge. Heard noise resident had fallen out of w/c. Has laceration to forehead [approximately] 3 cm [centimeters] length, width linear 0.1 cm edges approximated [and] steri striped [sic] [after] cleansing...Small am't [amount] bleeding from nose...Has red bruise area [approximately] 2 cm diameter on [right] knee...Denies pain except to head [and] nose...Assisted back into w/c by staff x [two]." The resident was transferred to the hospital on 4/25/11 at 4:00 A.M., and returned the same day at 7:10 A.M., with the steri strips left in place on the resident's forehead. On 6/13/11 at 12:15 P.M., the ADON (Assistant Director of Nursing) provided		assure that safety devices are in place and functional in accordance with the residents' plan of care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents' comprehensive assessment in correlation with the plan of care to assure that the pertinent information based on the assessment is accurately communicated and being followed in accordance with the residents' identified needs. Safety device placement and function will be specifically identified on the monitoring form. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** 6-29-11	

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	an "Incident/Accident Report," dated 4/25/11. The report included: "...Resident attempting to get up unassisted several times wanting to get up...resident gotten up per CNA in w/c, placed in TV lounge...Heard noise, resident on floor, w/c in normal position...Additional comments and/or steps taken to prevent recurrence: Education to new staff importance of CNA assignment sheet to keep on @ all times...." During interview at that time, the ADON indicated he was not employed by the facility on 4/25/11, and did not have additional information. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she was the nurse working when Resident A fell on 4/25/11. RN # 1 indicated a "new CNA" transferred the resident to a wheelchair, and did not place the lap tray on the wheelchair as ordered. On 6/15/11 at 10:45 A.M., the Assistant Director of Nursing [ADON] provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "Policy, To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls...." This deficiency was cited on 4/14/11. The facility failed to implement a systemic			

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	plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00088724. 3.1-45(a)(2)			